services on an actual cost basis, including 7% County administrative costs. This could potentially save BHD a significant amount of money, because the Federal Financial Participation (the amount Medicaid actually pays to providers) would be much greater as a result. However, different limitations apply for clinic services (i.e. outpatient and day treatment). The State agreed to continue to cover the costs related to day treatment and outpatient.

Services could be bundled together to reimburse at a residential level of care. This is significant to Milwaukee County, because currently the County reimburses 100% of the cost since Medicaid does not cover residential care. With the implementation of 1915(i), the County could draw down Federal Financial Participation (minus room and board).

Developing a Fee-for-Service Network

Mental health contracts providing direct client services will be converted to fee-for-service agreements in 2009 to take advantage of the newly enhanced Medicaid Federal Financial Participation revenue stream available via 1915(i) in 2010. 2009 will be a transition year to move the following contracts to fee-for-service: *Outpatient, Community Based Residential Programs*, and *Case Management* (i.e. CSP, TCM, & S+C). The Mental Health Advisory Council to the BHD Community Services Branch, consisting of consumers and contracted providers, has recommended the following timeline to convert programs to fee-for-service:

July 1, 2009: Community Based Residential Programs
September 1, 2009: Case Management Programs
December 1, 2009: Outpatient Programs

2009 contracts will be executed with providers for a partial year based on the timeline above or until the conversion to fee-for-service takes place. The balance of money that would otherwise have been used to fund the contracts for the entire year will be set aside as the fund source to purchase services once the conversions take place.

Another significant benefit of implementing fee-for service agreements is that the community mental health and substance abuse delivery systems will be much more closely aligned in terms of infrastructure and business processes. Historically, individuals with co-occurring mental health and substance use disorders received sequential or parallel treatment from the separate mental health and substance abuse treatment systems, resulting in fragmented and duplicative care. Establishing the same management information platform for both systems sets the stage to pursue co-occurring integrated care, and create clinical, operational, and cost efficiencies within one system. Some of the service descriptions contained in this RFP represent additional steps toward pursuing this endeavor.

NOTE – Agencies should assume a full 12-month contract period when filling out budget forms included in the Technical Requirements booklet (both agency and program specific forms) for the above programs.